IDAHO DEPARTMENT OF
HEALTH & WELFARE

C. L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

September 29, 2008

Christie Roach
Legacy Hospice
680 S Progress Ave, Suite 2A
Meridian, Idaho 83642

Provider #131546

Dear Ms. Roach:

On **September 24, 2008**, a complaint survey was conducted at Legacy Hospice. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00003745

Allegation #1: The Hospice agency did not respect or honor patients' and/or their familys' wishes for hydration and nutrition.

Findings: On 9/24/08, a surveyor made an unannounced visit to the agency. During the complaint investigation, the surveyor reviewed five patient records and interviewed staff.

All patient records contained an "Informed Consent" form, which was signed by patient and/or their Power of Attorney. The consent stated "I/WE fully understand that some medical services or procedures (advanced cardiac life support or respirators) are not provided by Hospice. Other services (such as intravenous therapy and transfusions, any type of restorative therapy or treatment .....are provided only if they are determined by your physician and the hospice IDG (Intra-disciplinary Group) to be necessary for the comfort of the patient in relation to the terminal illness.

One patient's record documented a 67 year old female patient who was discharged from a hospital on 7/15/08.

The hospital's "Transfer Orders", form dated 7/15/08 stated diagnosis at discharge was end-stage congestive heart failure, and her prognosis was "poor". The physician ordered hospice care at the time of discharge for the patient and she was transferred from the hospital to home via ambulance. The physician's order, dated 7/15/08, stated the patient was "...terminally ill and needs intermittent skilled and supportive care." The hospice's "Documentation of Hospice Eligibility" form, dated 7/15/08, stated the "...family was aware of the disease process and requested hospice palliative comfort care." It also described the patient as being "extremely lethargic, breathing very shallow and rapid."

On 7/16/08 at 1:30 PM, a nurse documented in the patient's record that the patient's family was trying to make the patient eat. She documented that she had "Instructed the family on the risk of PO (oral food) intake." On 7/17/08 at 12:30, the nurse documented "Educated family on end of life nutrition, hydration and the risk of artificial hydration. Husband decided at this time not to start IV fluids. Re-enforced (sic) education on PO fluids and the risk of aspiration, instructed daughter (name) to use pink sponge to keep oral cavity moist." On 7/18/08 at 1:30 PM, the nurse documented that the patient's family was with holding the patient's medications in order for the patient to "wake-up so they could try to feed her." The nurse stated that she educated the family to following the physician's orders and to give the patient her medications, and re-reviewed as to why the patient was an "aspiration risk." A "Narrative Note" dated 7/18/08 at 2:15 PM, written by the agency's Social worker stated, "(patient's name) children came to see her and her son (name), was getting angry that more aggressive measures were not being taken such as IV hydration and nutrition...(husband's name), verbalized understanding that at this time comfort measures are appropriate and 'we shouldn't force her to eat or drink'." She also stated that the "(patient's name) living will specifies her wishes for comfort measures."

On 7/21/08 at 12:00 PM, the Social Worker documented that there was a difference in opinions with the patient's family members on how aggressive the patient's medical care should be. She further documented that the husband was feeling "guilty" of his decision of "comfort care". On 7/21/08 at 4:00 PM, the nurse documented that the patient's family had "sent all of the patient's medical records over to primary physician, who agreed with hospital that patient (sic) only had days to live and comfort measure would be best. He (patient's husband) stated that some of the family members felt more could be done to lenthen (sic) her life, and wish to transfer agencies. I explained that we as a company would support his decision." The Social worker also documented that "some of the family members felt more could be done to lengthen her life, and wish to transfer agencies." The patient was discharged to a secondary agency on 7/21/08.

On 9/24/08 at 12:30 PM, the nurse who took care of the patient was interviewed. She stated that the physician had ordered comfort care for the patient on 7/15/08.

She stated the patient's husband, who was also the patient's Power of Attorney was being pulled by his step-children to seek more aggressive treatment for the patient. She said that she often educated the family of the philosophy of hospice and what "comfort care" meant. She said the patient was a high risk of aspiration and that she educated the family why this was. She said the family would try to feed the patient mashed potatoes, gravy and other food items despite physician's orders and education of the risk of their actions.

On 9/24/08 at 1:00 PM, the social worker who took care of the patient was interviewed. She said that physician's orders and the patient's advanced directives were reviewed with the family along with a book called "Hard Choices for Loving People". She stated the patient's husband was being pulled by his step-children to seek more aggressive treatment for their mother. She said that she educated the family on the philosophy of hospice and what "comfort care", meant. She said the family decided to seek more aggressive treatment for the patient and subsequently she was discharged from hospice.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: Patient's are given excessive morphine.

Findings: On 9/24/08, a surveyor made an unannounced visit to the agency. During the complaint investigation, the surveyor reviewed five patient records and interviewed staff.

All patient records contained a physician's order for a "Comfort Pak", which included an order for morphine sulfate 20 mg per milliliter to be used at 5 mg doses by mouth every four hours for pain. The Nursing 2008 Drug Handbook stated that a normal oral morphine dose was 5 to 30 mg every 4 hours.

One patient's record documented a 67 year old female patient who was discharged from a hospital on 7/15/08. Her diagnosis at discharge was end-stage congestive heart failure, and her prognosis was "poor". The physician ordered a "Comfort Pak" for the patient that included orders for Morphine Sulfate 20 mg per milliliter to be used at 5 mg doses every four hours on 7/15/08. On 7/17/08 the physician increased the morphine to 50 mg every hour as needed then on 7/18/08 the morphine was changed to 10 mg every hour for mild pain or respiratory distress or 20 mg every hour for moderate pain or respiratory distress.

Nursing notes documented that the patient's family was not using the morphine to treat the patient's pain or respiratory distress on 7/16, 7/17 and 7/18/08.

Social worker notes documented that the patient's family was not using the morphine to treat the patient's pain or respiratory distress on 7/21/08.

On 9/24/08 at 12:30 PM, the nurse who took care of the patient was interviewed. She stated that the patient's family was hesitant to use the morphine to treat the patient's pain or respiratory distress. They felt that if the patient did not receive the medication she would wake up and eat. She said that she would encourage the family to follow the physician's orders but they would not follow through with the instructions.

The nurse was following the physician's orders. Issues of physician ordered medication doses are issues of the Board of Medicine or civil malpractice. Physician prescribing practices are not covered under state or federal regulations.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As none of the complaints were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

PATRICK HENDRICKSON
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

PH/mlw